Psychiatry and Chinese Culture

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When we examine the cultural characteristics that influence mental disorders and related behavior among the Chinese, no major differences are found between Chinese and other groups in the range of disorders or in overall prevalence. Several cultural factors influence the recognition and treatment of mental illness, among which are attitudes toward emotional display, somatic as opposed to psychogenic disorders and features of the traditional medical belief system in Chinese culture. The Chinese have a relatively favorable prognosis of schizophrenia, low rates of depressive illness, a strong tendency towards somatization and the presence of several unique culture-bound syndromes. From studying Chinese in Vancouver, it was found that they have a characteristic way of dealing with mental illness in the family, in that there is first a protracted period of intrafamilial coping with serious psychiatric illness, followed by recourse to friends, elders and neighbors in the community; third, consultation with traditional specialists, religious healers or general physicians; fourth, outpatient or inpatient treatment from specialists, and, finally, a process of rejection and scapegoating of the patient. The efficacy of Western psychiatric treatment of Chinese patients has yet to be objectively assessed.

From a growing body of accumulated scientific observations, especially in the past three decades, certain differences are becoming apparent in the ways Chinese patients manifest the symptoms and course of mental disorders and in which the family and society treat and cope with mentally ill persons. This has led to such important questions as the relative vulnerability and tolerance of the Chinese to specific stresses and the extent to which Chinese culture with its traditional health beliefs and practices influences the perception and management of mental illness and mental health-related behavior.

In examining the role Chinese culture plays in shaping psychiatry and mental health services, I have attempted to address four questions:

- Are there psychiatric phenomena peculiar to the Chinese?
- Are there psychiatric treatment modalities that are unique to the Chinese?
- Have the Chinese with their sociocultural traditions developed unique coping skills which have expressed themselves in a pattern of help-seeking and delivery of mental health services?
- Do the Chinese have a system of psychiatric knowledge or theory peculiar to Chinese culture, especially regarding causation, manifestation and evolution of mental illness and its intervention?

Characteristic Features of Mental Disorders Among the Chinese

There exist basic similarities in the psychopathology of mental disorders between the Chinese and the people of Western and other cultures. Two major similarities have been variously reported in the past and substantiated by the International Pilot Studies of Schizophrenia of the World Health Organization (WHO) and other international collaborative studies.[1,2] The first important feature is that the entire range of psychopathology observed in the West and in other cultures in terms of symptoms or syndromes have been observed in the Chinese. Second, all types of mental disorders including their subtypes, as described in Western literature, have been identified among the Chinese when standard Western diagnostic criteria are applied.

The overall prevalence rates of mental disorders and the rates for psychoses among the Chinese have been reported as roughly similar to, or at the lower end of,

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the reported rates of those from other cultures.[3] Such observations, however, cannot be yet regarded as conclusive or meaningful. Because epidemiologic studies that have been carried out in Chinese and other cultures up to the present vary significantly in their scope, methods of case finding, diagnostic criteria, sociodemographic measurements and data analysis, they have yielded no data for meaningful comparisons, especially where the overall rates of mental disorders are concerned.

Major Psychoses

Observations on certain specific types of mental disorders are amenable for comparison with other studies by virtue of the use of better defined diagnostic criteria.

Schizophrenia. The prevalence rates of schizophrenia in various studies range from 1.1 to 4.0 per 1,000, which are in the lower range of rates reported from other cultures.[3-6] It should be noted, however, that the above findings require further confirmation through systematic epidemiologic studies using standardized research methodology and well-defined criteria.

Two significant features among Chinese who have schizophrenia seem to stand out from the reported findings. First, a large percentage of schizophrenic patients in Taiwan are diagnosed as paranoid both in clinical and systematic comparative studies.[2-7] Second, the data obtained from Taiwan and Hong Kong seem to indicate a considerably favorable prognosis for schizophrenic Chinese. The Chinese schizophrenic patients in WHO's pilot study showed better prognoses than those from Western countries after two years and five years.[1] In Hong Kong two thirds of schizophrenic patients were found to have a lasting remission or showed only mild deterioration at a ten-year follow-up.[8] The hospital statistics I obtained during my visits in 1981 and 1982 also suggested a benign prognosis for schizophrenic patients in China.

In addition, to investigate the role biogenetic factors might possibly have in the favorable outcome of schizophrenia, the contribution of psychosocial factors peculiar to Chinese culture should be explored. It is conceivable that the strong supportive network traditionally embodied in Chinese families and the community may play a key role. It is also possible that the preindustrial Chinese societal structure, with its well-defined roles and functions for each person, might place fewer demands on sick persons and thus make it easier for them to regain their prescribed roles and functions.

Affective psychoses. Prevalence rates of affective psychoses in Taiwan and Hong Kong are lower than generally assumed rates in other cultures.[4,5,9,10] Manic disorders are in the majority in most studies. Whether this finding is due to underreporting of cases of depression or to overreporting of cases of mania because of differing cultural tolerance of the Chinese to the psychopathology of mania rather than depression deserves further study.

Senile psychoses. In sharp contrast to in the West, care for aged persons with senile psychoses has not been a major problem for families, society or psychiatric institutions in Chinese society. The prevalence rates of senile psychoses in a Taiwan survey[4] and rates of patients older than 60 years admitted to hospital with psychosis in Hong Kong[9] are relatively low. These findings should not be taken to indicate that senile dementia does not develop in Chinese or that they do not suffer from senile psychoses. The age-specific rates of senile dementia and psychoses in the Taiwan study are found to be comparable with those reported from Bavaria and Thuringia. It is conceivable that the low hospital admission rates of senile psychiatric patients reflect the protective attitude of the Chinese toward old people, sick or well. It is postulated that the Chinese community has a higher tolerance for old people, making them feel loved, wanted, respected and useful, which gives them a sense of self-respect and belonging. How much such traditional attitudes help retard the aging process or influence onset and course of senile psychoses is a subject for future medicosocial inquiry.

Minor Mental Disorders and Culture-Bound Syndromes

In the case of minor mental disorders and culture-bound syndromes, three elements seem to predominate in most studies regardless of whether they are based on hospital statistics or community surveys: (1) the very low prevalence rates of depressive illness, especially neurotic depression, (2) the large number of patients diagnosed as "neurasthenic" and (3) the relatively few cases of obsessive-compulsive neurosis among Chinese.

Depressive illness. It is fair to state that depressive illnesses among the Chinese have so far received little attention largely due to their perceived low prevalence rates. Findings from hospitals and outpatient clinics in the People's Republic of China confirm the generally held view that depressive illnesses are rarely diagnosed. For example, less than 3% of outpatient-clinic patients and about 1% of inpatients are diagnosed as having depression.

Several reasons have been suggested to account for the rarity of reported cases of depressive illness among the Chinese:

(1) The characteristics of depression, consisting mainly of dysphoric mood change, self-depreciation and guilt feelings, do not fit in with the traditional concept of "madness" in Chinese society, which emphasizes outward antisocial or bizarre behavior as the pathognomonic features. Therefore, persons with dysphoric conditions neither seek psychiatric help nor get reported in epidemiologic surveys.

(2) A Chinese reluctance to express or discuss one's own feelings, especially to anyone outside of the family, may also play a part in inhibiting the expression of depression.[11]

(3) Somatization, a prevalent form of symptom manifestation in Chinese psychiatric patients, especially in the case of minor mental disorders, is felt to play an important role in influencing the diagnosis of depression.[3,12-14] The application of Western diagnostic criteria

of depression, which consists mainly of the presence of dysphoric symptoms, would leave out a large portion of depressed Chinese whose prevalent symptoms are predominantly somatic and vegetative.[15] The recent research findings in Changsha, Hunan, where 87 of 100 cases of neurasthenia were rediagnosed as depressive disorders further support the important role of somatization in depressive psychopathology among the Chinese.[16]

Indirect but potentially important supportive evidence of somatization can be found from linguistic studies. It has been pointed out that the Chinese words expressing the emotional state of dysphoric mood or depression are surprisingly limited compared with the richness of somatic expressions to denote other emotions.[17]

(4) One cannot overlook the real possibility that indeed the Chinese people suffer less depression. It is hypothesized that such pathogenetic conditions for depression as divorce, alcoholism and drug abuse are less prevalent in China, whereas mutual help through an extended family or neighborhood alliance is more readily available for those under stress in Chinese society. This hypothesis deserves a systematic inquiry.

Neurasthenia. My visits to the People's Republic of China have confirmed the many reports of visitors and Chinese psychiatrists that neurasthenia is by far the diagnosis most frequently made in psychiatric outpatients.[16,18,19] There was even a large scale nationwide campaign against neurasthenia in the late 1950s and 1960s.[20]

The term neurasthenia seems to be variously defined, and is often used as a synonym for neurosis or even for minor mental disorders that include neurotic depression, anxiety states, hypochondria and hysteria. The vague and idiosyncratic usage of the term makes it difficult to objectively analyze many of the psychiatric findings reported on this condition—whether the focus is its epidemiology, causation, treatment or clinical and social significance. Most Chinese psychiatrists seem to be of the view that there exists a group of patients suffering from a similar morbid condition of neurasthenia, probably of similar biologic or neurologic causation as originally reported by Beard[21] and Ballet.[22]

The whole issue of neurasthenia calls for an intensive systematic and comprehensive clinical, epidemiologic and laboratory investigation. This research should use standard diagnostic criteria for redefining several subcategories that are labeled neurasthenia.

Obsessive-compulsive neurosis. The rarity of cases of obsessive-compulsive neurosis among Chinese has been consistently reported by observers through epidemiologic surveys and clinical statistics.[4,23] I made similar observations during my visits to the People's Republic of China. Tseng[24] regarded the strong ties of persons with a domineering and perfectionistic mother —a characteristic Chinese feature—to be the cause of ten cases of obsessive-compulsive neurosis he studied. He did not explain, however, why there are so few cases of obsessive-compulsive neurosis to be reported among the Chinese, if indeed such mother-son ties are specific to Chinese and by implication commonly found.

Culture-bound syndromes. A number of syndromes such as *koro,* frigophobia and *shen-k'uei* occur almost exclusively among Chinese. *Koro,* characterized by panic that the penis will shrink into the abdomen and the person will die, occurs mostly among young men of low social class with minimal education in South China, Hong Kong and Taiwan.[25,26] An epidemic of *koro* was reported in Singapore in 1969.[27,28] Frigophobic patients suffer from excessive fear and intolerance of cold in terms of temperature and foods of "cold" (yin) nature.[29] *Shen-k'uei* is characterized by weakness, fatigability, insomnia, anxiety and hypochondria. It is believed to be caused by excessive masturbation, nocturnal emission or intercourse, so it is often called sexual neurasthenia.

All of these syndromes have an important characteristic in common, that of somatization of anxiety or fear. It should be noted that traditional Chinese medical beliefs rooted in yin-yang theory play an essential role in the manifestation, perception and interpretation of the above conditions. How much culture-specific treatment modalities have been applied to deal with these syndromes is not known, as no such reports are yet available.

Another reported culture-bound syndrome, *hsieh-ping,* is a form of possession and a trance state, often associated with guilt or fear over laxity in ancestor worship.[4,30,31] It may be regarded as religiously sanctioned behavior or a coping mechanism. Similar pathological possessions occur in other cultures,[32] but these are not related to ancestor worship as with the Chinese.

Alcoholism

Alcoholism has never been a social or a medical problem in Chinese society anywhere in its long history, which can be regarded as a most remarkable cultural distinction.[4,33-37] The rarity of cases of alcoholism among Chinese assumes more significance in view of the popular use of alcohol for medicinal, culinary, social and religious purposes that is ingrained in their everyday living.

Although the Chinese high sensitivity to ethyl alcohol, due to a constitutional peculiarity, may in part account for their resistance to consuming large amounts regularly,[38] the social control mechanism of traditional Chinese society seems to play a significant role in preventing alcohol abuse.[39,40] It is conceivable, therefore, that westernization of the life-style accompanied by social disorganization and family breakdown, as seen in segments of Chinese society in Hong Kong, Taiwan and certain North American locations, might contribute to increased alcohol consumption leading to alcoholism. Concerns to this effect have been expressed in Hong Kong[41,42] and Taiwan,[20] but no noticeable increase has been observed in a community survey carried out in Vancouver[40] or in the People's Republic of China.[6]

Treatment Modalities of Mental Disorders

Western psychiatric treatments, with the notable exception of psychotherapy, have been widely applied in China and, to a considerable extent, have been generally accepted by the Chinese people. It is premature, however, to conclude that Western psychiatric treatment modalities are effective with Chinese patients, as there are few evaluative studies using comparable standardized criteria and research techniques. Even the widespread use of psychotropic drugs, electroconvulsive treatment and insulin shock treatments has yet to be objectively assessed for their effectiveness with Chinese patients through careful clinical research, taking into consideration various biologic, psychologic and sociocultural factors.

Cross-cultural psychopharmacology is an important issue to consider. For example, in my clinical experience, Chinese manic patients seem to require smaller doses of lithium carbonate per body weight and a lower blood concentration. In Japan similar findings were obtained through a large-scale collaborative evaluative study.[43] The antipsychotic drugs like phenothiazine derivatives can be effective on Chinese patients at about half the dose required by their Western counterparts.

Psychotherapy

That "Western insight-oriented psychotherapy is not acceptable to the Chinese and their effectiveness is in doubt" has become almost a conviction.[44-46] The fact that professional psychotherapy is not legitimized or available for the general population in Taiwan, the People's Republic of China or Hong Kong corroborates this general notion.[31] Such a common notion merits scrutiny, however; psychotherapy is and should be a central focus of psychiatry in any culture, for it distinguishes psychiatry from all other medical specialties as both a scientific system and a healing art.

The conclusion that insight-oriented psychotherapy is not applicable to Chinese patients is a premature one in that insight-oriented psychotherapy has not been properly and sufficiently applied to Chinese patients by well-trained Chinese psychotherapists, and most of the available reports lack clear descriptions of the type and method of specific psychotherapy applied. The development of psychotherapy both in its theory and techniques in the past 60 to 70 years has been such that it includes literally hundreds of different psychologic interventions. It is almost meaningless, therefore, to state whether Western psychotherapy works or does not work. A proper assessment requires a clear description of patients, their problems and backgrounds, and the actual methods, psychotherapeutic orientation, frequency and duration of treatment, targets or goals of treatment and assessment of the results to understand the effectiveness of the psychotherapy rendered.

Given the above reservations, the fact remains that there exists a considerable resistance to insight-oriented psychotherapy on the part of both the Chinese people as patients or family members and the Chinese medical system. The following hypotheses have been advanced to explain this deep-seated resistance:

- Chinese philosophy emphasizes harmonious interpersonal relationships, interdependence and mutual moral obligation or loyalty for achieving a state of psychosocial homeostasis or peaceful coexistence with family and other fellow beings.[11] This seems to have conditioned Chinese persons to seek the cause of their stresses or adjustment difficulties in their relationships with others rather than to look inward.
- For the Chinese, emotion or sex belongs to a person's privacy, which is jealously guarded from anyone outside the immediate family circle. Chinese are taught to avoid at all cost talking to outsiders of one's own private life or of feelings and emotional life with family members.[11]
- The medical belief system in Chinese culture seems to act against the use of psychotherapy as a way of resolving conflict because of the former's emphasis on organic causation of mental illness and the tendency to somatization.[17]
- The reliance on verbal communication as the sole or major tool for psychotherapy may make it difficult for Chinese people to accept, for they by tradition or training rely a great deal on nonverbal communication or symbolic figurative expression in conveying their emotions.

Certain elements in psychotherapy may be used effectively in treating Chinese patients. For instance, it is conceivable that family therapy may be a preferred approach in restoring patients' interpersonal equilibrium with the significant people in their lives. An effective use of nonverbal communication including body language should be encouraged for inclusion in the treatment techniques in Chinese culture. It is conceivable that a psychotherapist might take a more direct approach in manipulating the physician-patient relationship, at least in its early stage, to make patients accept the therapist's treatment modality. Through experimental studies one could test the above-mentioned hypotheses, which would further refine psychotherapeutic techniques for Chinese patients.

Coping, Help-Seeking and Provision of Mental Health Services in Chinese Culture

One consistent finding in Chinese communities all over the world is that the family plays a key role in coping and help-seeking when a member becomes mentally sick. However, some changes are being observed in Hong Kong and other rapidly westernizing Chinese communities in which the family appears to be playing a lesser role in taking care of the sick.[42]

From our research in Vancouver, it was found that Chinese families have a specific coping pattern for dealing with a serious psychiatric illness in the family.[47-49] This pattern is characterized by five distinctive phases that as a rule follow a typical sequential order. Phase 1 is a protracted phase of exclusively intra-

familial coping, sometimes lasting from 10 to 20 years. Attempts are made by the family to influence the abnormal behavior of the sick member with every possible remedial means and resource within the family to its limit of tolerance. This is followed by phase 2 in which trusted outsiders like friends and elders of the community are asked to help the family cope with the problems of correcting the abnormal behavior of the sick member. Phase 3 is characterized by inviting outside helpers such as herbalists, physicians or religious healers to attempt to treat the psychotic person who is still kept inside the family.

Phase 4 occurs when the sick member is labeled a mentally ill person by a physician or a trusted outside agency with which the family consults. This labeling also implies that the family has reached the limit of its resources in dealing with the psychotic member. A specialist's help is sought first on an outpatient basis and later, in-hospital treatment may be accepted. When the hope for recovery of the sick person fades and the psychologic and financial burden of caring for a mentally ill family member becomes unbearable, the final phase of rejection and scapegoating, phase 5, sets in. The family gives up hope and is reconciled with its "fate" of having a mentally ill patient in its midst for the rest of the patient's life or who is kept in a far-away mental hospital so that the family no longer has to think about him or her. Certain events of life or persons and sometimes bad spirits or bad *feng-sui* ("geomancy") are blamed for the fate of their having to be landed with an unfortunate, ill-starred mentally ill member.

As regards minor mental disorders, the pattern of help-seeking differs greatly from that with major psychoses, resembling more the help-seeking behavior for physical disorders.[50] It commonly starts with self-medication, followed by consulting Western-style doctors, then to Chinese-style practitioners and finally to a Western-style hospital for physical diseases. The sequential order of the above help-seeking may vary in some cases depending on the availability of services and the educational or socioeconomic condition of the family. Seldom do they end up in psychiatric facilities, especially inpatient services. As a rule, traditional Chinese medical practitioners play a more prominent role in the neurotic cases involving sexual dysfunction like *shen-k'uei.*

Traditional Medicine and Mental Disorders

Traditional Chinese medicine has retained its theoretic frame of reference and medical beliefs into the modern age and is still exerting an important and pervading influence on the symptom formation of mental illness and mental health-related behavior of patients and their families.[51-54]

In Chinese medical thought,[16,55-57] psychosomatic integration characterizes the relationship between psychologic and physiologic functions. According to its theory each of the five major emotions has a corresponding internal organ: the site of happiness is the heart, anger the liver, worry the lung, fear the kidney and desire the spleen. The imbalance of emotions disturbs the functional balance of these organs and vice versa. The excess, incongruence or lack of harmony of emotions is regarded as pathogenic, and a high value is placed on moderation and inhibition of emotions or affective expression. Once the physiologic balance is disturbed due to psychologic imbalance, however, methods of treatment are sought in physiologic or medical intervention rather than psychologic. The training of body-mind together, like *tai-chi,* is more valued as a preventive means than as therapy to restore emotional imbalance.

Chinese traditional medicine seems, therefore, to have exerted an inhibiting effect on psychiatry to develop into an independent system of psychologic medicine as in the West. Indeed, psychiatry has been given throughout Chinese history a marginal place in the total medical system.

Nevertheless, one should not underestimate the significant influence of traditional medical beliefs peculiar to Chinese culture on the manifestation or treatment of mental disorders. For instance, the prominent role somatization plays in the psychopathology of mental disorders and in illness behavior, as discussed above, has its origin in traditional medical thought, which is deeply imbedded in the everyday life of the Chinese. It certainly influences the preferred modes of treatment. It also offers an effective defense against the shame and guilt associated with mental illness, for the psychologic burden of a sick person or the person's family is greatly relieved by somatization, which represents an acceptable explanatory model to all concerned. Although somatization is not exclusively confined to the Chinese people or culture alone, its intensity and pervasiveness are such that Chinese somatization has a unique quality.[15,58]

A plausible explanation for Chinese somatization lies in the cultural emphasis on a "situation-oriented" approach to life. In the Chinese view, a person is a relational being living and interacting in a massively complicated role system.[59] Chinese culture emphasizes harmonious personal relationships as the fundamental element in achieving psychosocial homeostasis.[11] To the Chinese mind, harmony, interdependence and loyalty are keys to survival, peace and happiness. The unique quality of Chinese somatization can thus be regarded as having two major cultural roots—traditional medical beliefs and a situation-related approach to life.

Finally, one should always keep in mind that Chinese culture varies in different communities and is constantly changing despite the commonly held notion of its stability, durability and continuity for more than 20 centuries. The fact remains that it is changing with time and place through contact with outside influences and through its own evolution and revolution. This factor of variation and change should be taken into consideration when one looks at certain observed facts or attempts to grasp the conceptual frame of reference of any observation.

Conclusion

It is evident from the above that the question, Is there a Chinese psychiatry? cannot be responded to with an affirmative reply at this stage of psychiatric development. There is a hope, however, that some of the gaps in psychiatric knowledge and theory might be filled and a more cohesive scientific system developed in the not-too-distant future, if the current lively psychiatric research in Chinese communities continues.

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